MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

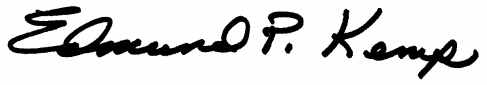
NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division
Bureau of Medicaid Policy and Actuarial Services

Project Number:	0628-Home Help	**Comments Due:**	February 22, 2007	**Proposed Effective Date:**	April 1, 2007

Mail Comments to: Susan Yontz
Bureau of Medicaid Policy & Actuarial Services
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Telephone Number: (517) 335-7500

Fax Number: (517) 335-5136
E-mail Address: yontzs@michigan.gov

Policy Subject: Home Help Provider Agreement

Affected Programs: Medicaid

Distribution: Home Help Providers

Policy Summary: This policy introduces a new provider agreement required of all providers of Home Help Services. The provider agreement replaces the previously required Statement of Employment.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Home Help

Issued: March 1, 2007 (Proposed)

Subject: Home Help Provider Agreement

Effective: April 1, 2007 (Proposed)

Programs Affected: Medicaid

All providers of Medicaid services are required by federal regulation and program policy to complete and sign an agreement stating that they will abide by Medicaid policies in rendering services to program beneficiaries and in receiving payment from the program. To meet this requirement, a new Home Help Provider Agreement (MSA-4676) has been developed to replace the Services Statement of Employment that was previously required of home help providers.

All home help providers, including independent service providers and home help agencies, must complete this new agreement upon the opening, change, or renewal of a beneficiary's home help service plan and submit it to the Michigan Department of Human Services (DHS). An individual home help provider or provider agency must complete the Provider Agreement only once regardless of the number of beneficiaries to which the individual or agency provides services.

Instructions for completing the Home Help Provider Agreement are included as part of the agreement. Independent providers, those not affiliated with a provider agency, are to attach a copy of current pictured identification (such as a valid driver's license or a state ID card) and a copy of the provider's Social Security card to the provider agreement when submitting the form. Adult Services Workers with DHS will be able to assist with any questions related to completion of the Provider Agreement. Once the agreement has been completed and signed, the Adult Services Worker will forward a copy, including attachments, to:

Michigan Quality Community Care Council (MQCCC)
1115 S. Pennsylvania, Suite 203
Lansing, MI 48912

Toll free: (800) 979-4662
Local: (517) 999-3130
Email: info@mqccc.org

The MQCCC, under contract with the Department of Community Health, maintains a database of all home help providers.

Home help providers or provider agencies may not continue to provide services to a home help beneficiary beyond December 1, 2007 unless a correctly completed and signed Provider Agreement is on file with DHS. The local DHS office is responsible for ensuring that the provider agreement is maintained in its files for each home help provider or provider agency enrolled in and receiving payment from the Medicaid Home Help program.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

Dear Home Help Provider:

Attached is the Medical Assistance Provider Agreement used to enroll prospective Home Help providers as a Medicaid provider in the Michigan Medicaid Program.

Subject to approval, your enrollment begins the date you sign the provider agreement. Payment for services will begin when a beneficiary has chosen you as a provider and the beneficiary's hours have been approved by the Department of Human Services (DHS).

You must present the completed Provider Agreement, a copy of current pictured identification (i.e. driver's license, state identification card, etc.) and a copy of your social security card, within ten (10) days from the date you sign the agreement, to an adult services worker at your local DHS office. The worker will forward a copy of the completed agreement and attachments to:

Michigan Quality Community Care Council (MQCCC)
1115 S. Pennsylvania, Suite 203
Lansing, Michigan 48912

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The MQCCC, under contract with the Department of Community Health, maintains a central database of all Home Help providers. A properly completed Provider Agreement (MSA-XXXX) must be received by DHS before provider payments can be initiated.

Retain a copy of the signed agreement for your records.

Receipt of the completed Provider Agreement does not guarantee enrollment in the Medicaid Home Help Program. You must meet all general and service specific enrollment criteria established by the Michigan Department of Community Health and the Michigan Department of Human Services to enroll as a Home Help provider.

If you have any questions about this Provider Agreement, please contact an Adult Services Worker at your local DHS office for additional information.

Sincerely,

Medical Services Administration

Distribution: Original - MQCCC
COPY 1 - Local DHS Office
COPY 2 - Provider

Medical Assistance Home Help Provider Agreement Acknowledgements and Conditions

IN APPLYING FOR ENROLLMENT AS A HOME HELP PROVIDER IN THE MEDICAL ASSISTANCE PROGRAM, I AGREE TO AND ACKNOWLEDGE THE FOLLOWING:

1. All information furnished on this Medical Assistance Home Help Provider Enrollment Agreement is to the best of my knowledge accurate and complete.
2. To provide services according to the beneficiary's DHS Adult Services Comprehensive Assessment. I agree to notify the beneficiary's DHS Adult Services Worker of need for any changes in the beneficiary's care within 10 days of becoming aware of the need for the change.
3. To notify the DHS Adult Services Worker of any absence from the home by the beneficiary (i.e., hospitalizations, vacations, or death) within 10 days of being aware of the absence.
4. To submit quarterly Personal Care Services Provider Log (DHS-721) as a record of services provided. The Provider Logs submitted by me to DHS will be maintained on my behalf by DHS in accordance with state and federal laws and regulations. Should I fail to submit a Provider Log, payment for services rendered may be withheld until such time as I submit the Provider Log.
5. As an individual Home Help provider, payments for Home Help Services will be made as two-party checks between the beneficiary and myself. Payments will be sent directly to the beneficiary's address. Agency providers receive single-party checks mailed directly to the agency.
6. To comply with all applicable policies and procedures pertaining to the Medical Assistance Home Help Program.
7. To repay the State of Michigan for all overpayments, including payments for services that I did not provide. I understand that all Home Help Program payments are made using federal funds. Therefore, I am subject to federal as well as state prosecution for any fraud committed. I agree that disputed claims, including overpayments, are to be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction.
8. To accept the payment received from DCH for the Home Help services provided as payment in full. Except for DHS-authorized deductibles, I agree not to seek or accept additional payments from the beneficiary or beneficiary's guardian for DHS-authorized Home Help services.
9. To return to the State of Michigan any monies received from other insurance carriers for Home Help services provided to DHS beneficiaries up to the amount paid by DCH for the services.
10. As an individual or an agency, to provide full disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
11. If any provision of this agreement is found to be illegal, invalid, or unenforceable, the remainder of the Agreement will continue in full force and effect.
12. If I am receiving Medical Assistance or any other public assistance, to report all Home Help income received by me to my DHS Eligibility Specialist.
13. To comply with the privacy, security, and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A, C, and E).

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Medical Assistance Home Help Provider Agreement Acknowledgements and Conditions

CONDITIONS OF EMPLOYMENT

1. I am employed by the beneficiary as a contractor to provide Medical Assistance Home Help Services to the beneficiary. I am not an employee of the Department of Community Health or the Department of Human Services.
2. The beneficiary has the right to choose, hire, direct, and discharge me as his/her provider at any time.
3. I agree to notify DHS within ten (10) days of any change in my employment status with the beneficiary.
4. I agree to allow DCH to withhold Federal Insurance Contribution Act (FICA) taxes from my Home Help provider payments when required by the IRS. FICA deductions are required whenever services are provided to a beneficiary other than a parent or child. They may be deducted, at my request, for a parent or child but are not required to be.
5. DCH will remit W2 forms in accordance with standard accounting practices. Further, I agree to notify DHS within ten (10) days of any change in my address.
6. I agree to furnish current picture identification (such as a valid driver's license or a state ID card) and my original Social Security card at the provider interview. Copies will be made of these documents to be included as part of the Provider Agreement.
7. The Provider Agreement is an application for participation in, and to receive payments from, the Medicaid Home Help Program. The Department of Community Health reserves the right to refuse enrollment and participation in the program. Completion of the Provider Agreement is not a guarantee of employment by the beneficiary.

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Michigan Department of Community Health

Medical Assistance Home Help Provider Agreement

(FOR OFFICIAL USE ONLY)	
PROVIDER ID NUMBER	PROVIDER TYPE **01**

SECTION 1 (INDIVIDUAL PROVIDERS ONLY)

1. INDIVIDUAL HOME HELP PROVIDER NAME (FIRST, MI, LAST)		2. PROVIDER SSN (Required) - -	3. DATE OF BIRTH / /
4. PROVIDER ADDRESS (NO. AND STREET, APARTMENT OR LOT NO)		5. TELEPHONE NUMBER ( ) -	
6. P.O. BOX NO.	7. CITY	8. STATE	9. ZIP CODE

SECTION 2 (AGENCY PROVIDERS ONLY)

10. AGENCY PROVIDER NAME		11. TAX ID NO. (Required for Agencies)		
12. AGENCY PROVIDER ADDRESS (NO. AND STREET, SUITE NO)		13. AGENCY TELEPHONE NUMBER ( ) -		
14. P.O. BOX NO.	15. CITY		16. STATE	17. ZIP CODE
18. CONTACT PERSON (AGENCY OWNER OR AUTHORIZED REPRESENTATIVE)				
19. A. OWNER NAME(S):		EFFECTIVE	% OWNED	OWNER SSN - -
B. OWNER NAME		EFFECTIVE	% OWNED	OWNER SSN - -
C. OWNER NAME		EFFECTIVE	% OWNED	OWNER SSN - -

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SECTION 3 (TO BE COMPLETED BY *BOTH* INDIVIDUAL AND AGENCY PROVIDERS)

20. HAVE YOU BEEN CONVICTED OF A CRIME PROHIBITING YOU FROM RECEIVING PAYMENTS FROM FEDERAL OR STATE FUNDS?
☐ NO ☐ YES - If YES explain:

HOME HELP PROVIDER

- The provider is the employee of, and provides Home Help services to, a Michigan Medicaid beneficiary, as authorized by DHS. The provider is NOT an employee of the Department of Community Health (DCH) or the Department of Human Services (DHS).
- If the provider receives payment for services he or she did not provide, the provider agrees to repay the State of Michigan. (See ACKNOWLEDGEMENTS, #7)
- The provider must complete and return a PERSONAL CARE SERVICES PROVIDER LOG (DHS-721) to DHS for each Home Help beneficiary to whom he/she provides services. If the provider fails to return the Provider Log, payment may be withheld. (See *ACKNOWLEDGEMENTS*, #4)
- If a provider is on public assistance, he/she agrees to report all Home Help income received to DHS. (See *ACKNOWLEDGEMENTS*, #12)

DEPARTMENT OF COMMUNITY HEALTH (DCH)

- The DCH is the funding source for the Home Help Program.
- Under provisions of this Agreement, DCH will make payment, through two-party checks made out to both the beneficiary and provider, for services authorized by DHS. (See *ACKNOWLEDGEMENTS*, #5)
- By signing this agreement, the provider acknowledges that he/she may be subject to a criminal history background check. Results of the criminal history background check may be used in hiring decisions.
- By signing this agreement, the provider authorizes DCH to deduct FICA taxes when required by the IRS or at my request (See *ACKNOWLEDGEMENTS*, #17)

By signing the Provider Agreement, I acknowledge that I have read the Provider Agreement, the included instructions, and the Acknowledgements, and I agree to fully comply with all program requirements

SIGNATURE - HOME HELP PROVIDER or AUTHORIZED AGENCY REPRESENTATIVE	DATE

AUTHORITY: P.A. 280 of 1939, as amended
COMPLETION: Required
PENALTY: Application may not be approved

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Medical Assistance Home Help Provider Agreement

Instructions for Completing the Home Help Provider Agreement

SECTION 1: TO BE COMPLETED BY INDIVIDUAL HOME HELP PROVIDERS NOT AFFILIATED WITH AN AGENCY.

1. **HOME HELP PROVIDER NAME:** Enter the first, middle initial and last name of the Home Help provider applicant.
2. **PROVIDER SSN:** Enter the Social Security Number of the provider applicant.
3. **DATE OF BIRTH:** Enter the birth date of the provider applicant (MM/DD/YYYY).
4. **PROVIDER ADDRESS:** Enter the full street address of the provider applicant including street number, street, and, if applicable, apartment or lot number.
5. **TELEPHONE NUMBER:** Enter the current telephone number, including area code, to reach the provider applicant.
6. **P.O. BOX NUMBER:** Enter the Post Office Box number (where applicable).
7. **CITY:** Enter the city where the provider applicant resides.
8. **STATE:** Enter the state where the provider applicant resides.
9. **ZIP CODE:** Enter the corresponding zip code for the provider applicant's address.

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SECTION 2: TO BE COMPLETED BY AGENCIES PROVIDING HOME HELP SERVICES.

10. **AGENCY PROVIDER NAME:** Enter the complete name of the agency provider.
11. **TAX ID NUMBER:** Enter the IRS Tax ID number for the agency.
12. **AGENCY PROVIDER ADDRESS:** Enter the full street address of the agency, including street number, street, and, if applicable, suite or unit number.
13. **AGENCY TELEPHONE NUMBER:** Enter the phone number where the authorized representative of the provider agency can be reached.
14. **P.O. BOX NUMBER:** Enter the Post Office Box number (where applicable).
15. **CITY:** Enter the city where agency provider is located.
16. **STATE:** Enter the state where agency provider is located.
17. **ZIP CODE:** Enter the corresponding zip code for agency provider's address.
18. **CONTACT PERSON:** Enter the name of the agency owner or other authorized representative.
19. **OWNER NAME(S):** Enter the name(s) of any person owning at least a 5% share of the provider agency. (Attach additional pages if needed.)

SECTION 3: TO BE COMPLETED BY BOTH INDIVIDUAL AND AGENCY PROVIDERS.

20. If the provider applicant has been convicted of a crime involving Medicare, Medicaid, or a Title XX program that would prohibit him/her from receiving state or federal reimbursement, provide details regarding the conviction (i.e., nature of the crime, court where the conviction was entered, date the conviction was recorded, and date the sentence was completed).